

Removal En Bloc of Epithelioma of the Penis.—MAUCLAIRE (*Archiv. gén. d. chir.*, 1908, 11, 247) says that in the treatment of cancer we should practice wide removal of the growth and should, as far as possible, avoid inoculating the wound surface during the operation. The latter object is best attained by trying to remove en masse the infected glandular area and the tumor. Mauclaire did the following operation for cancer of the penis: An antiseptic compress was wrapped about the end of the penis to protect the operative wound from infectious or neoplastic contamination. In the first stage he dissected the skin over the right inguinal region with the underlying connective tissue and the lymph glands down to the aponeurosis and femoral vein, in a triangular area, inward to the pubic symphysis. The second stage consisted of a similar procedure on the left side. In the third stage he made a transverse incision three fingers' breadth above the root of the penis. In raising the skin and connective tissue here a small gland may be encountered. In the fourth stage all the tissues of the penis are divided from above downward, including the lateral portion of the scrotum, so that all the lymphatics passing in this region shall be removed. All the tissues removed are thus in one piece. After ligating the bleeding points the suprapubic skin and that of the scrotum are brought together and sutured to the stump of the penis. The urethra is easily divided and separated, and its lateral margins everted and sutured to the skin of the scrotum. The margins of the rest of the wound are then brought together by sutures; a catheter is left in the bladder and dressings applied to the wound. Epithelioma of the penis is often developed from warts, plaques of leukoplakia or a phimosis. Its evolution is generally very slow. Lymphatic involvement is irregular as to its location and extent. There may be from the beginning cancerous involvement of the inguinal and iliac glands. Therefore, we should remove early, and in mass, the tumor and the bilateral lymphatic region. The removal should be wide in order to increase the chances of passing the infected territory and avoid operative grafting of the cancer.

The Various Forms of Puerperal Mastitis and Their Treatment.—FEINEN (*Deut. Ztschr. f. Chir.*, 1908, xclv, 357) quotes and seems to agree with Fleck in the statement that there is no longer any doubt that mastitis is almost always due to the penetration of bacteria, by the lymph paths, from abrasions or fissures of the nipple. The bacteria are chiefly staphylococci; more rarely streptococci; in a few cases gonococci, typhoid bacilli, micrococcus, tetragenus, colon bacilli, etc. The infection occurs generally in from the second to the fourth week. Broucha reported one case in which it developed twelve hours after birth. The forms of mastitis are classified into four groups: very acute inflammations, mammary abscesses, interstitial or parenchymatous mastitis and the gangrenous form. To these may be added the tubercular. The clinical features of the acute inflammatory, the abscess, and the gangrenous forms are too well known to require special attention. The correct diagnosis of the interstitial or parenchymatous is more difficult. When only a part of the gland is diseased and the inflammation is visible in the skin only through a doughy swelling, and in the deeper part a diffuse hardening with no fluctuation is felt, and when in consequence of the radiating arrangement of the ducts and lymphatics of the gland, the

inflamed area is broad at the periphery and gradually narrows at the nipple, the diagnosis of the interstitial or parenchymatous may safely be made. In such cases there is not a total melting away of the interstitial connective tissue, nor a confluent abscess formation. It presents the picture of an intracanalicular mastitis. Feinen sums up the treatment of the different forms as follows: In cases of early inflammations the antiphlogistic treatment is best. This consists in placing the affected breast mechanically and functionally at rest. The child is weaned, the milk is not withdrawn, and a purge is given. The breast is fixed to the thorax and moist dressings applied. In from two to four days the inflammation subsides. In cases of circumscribed mammary abscesses a small incision into the abscess and suction by cupping, according to the Bier method, gives the best results. In cases of interstitial mastitis, the new operation of Bardenheuer, gives the best results. This consists in raising the breast by an incision along its lower border. The whole gland is separated from the pectoral fascia. The abscesses are then incised and drained from the posterior surface, and the wound surface cleansed of all infected tissue. It heals by granulation. Only a single operation is required and this is simple and exact and gives the best cosmetic result. There is no scar on the surface of the breast, and only a linear scar at the lower border, which is obscured by the overhanging breast. The remaining gland tissue preserves its function and only the diseased tissue is removed. Finally, because of the small amount of scar tissue, it offers the least probability of cancer formation. In the gangrenous forms the simple removal of the gangrenous parts is advised. In all cases of puerperal, tuberculous mastitis, amputation is the only treatment considered.

The Gleich Operation and its Results in the Therapy of Flat-foot.—FRISCH (*Archiv f. klin. Chir.*, 1908, lxxvii, 324) describes the Gleich operation as performed in Eiselberg's clinic as follows: An oblique incision, a finger's breadth above the external malleolus, divides the skin, subcutaneous tissue, tendo Achillis and periosteum of the calcaneus. The margins of the wound are retracted with sharp hooks and the tuberosity is chiselled through, with as smooth a surface and as little splintering as possible. The periosteum on the far side of the bone wound is divided with a sharp knife in order to obtain free mobility of the separated piece of bone. This is displaced downward about the thickness of the small finger and slightly inward. If in any case the valgus position is especially marked, this lateral displacement of the tuberosity should be somewhat more marked. How far forward the fragment may be pushed will depend upon the angle of the chiselled surface. If this is in the right direction, as the fragment is pushed downward it may also be displaced anteriorly. While it is being held in the desired position it is fixed by a nail driven from the summit of the tuberosity through the fragment into the body of the calcaneus. The operation can be done aseptically throughout, and after the proper skin sutures are introduced and dressings applied, a plaster bandage may be put on without drainage. Frisch recommends this operation for severe cases, because of its simplicity and permanent results. The support of the arch will be so changed by the alteration in the position of the tuberosity of the os calcis, that the anterior or chief end of the